Naval Hospital Oak Harbor Prime Health Center
School Age (6yr-9yr) Well Child Visit

Date:
Time:

Provider Note

Interval History:

Review of Systems:

Past Medical History:

Medications:
Allergies:
Immunizations:
Family/Social History Update:

School Performance:

Physical Exam

Weight: _____ kg _____ lb _____%ile
Length: _____cm _____ in _____%ile
Body Mass Index: _____ kg/m^2 _____%ile

Vital Signs ❒ N/A
Temp: _____
RR: _____
O2 Sat: _____
HR: _____
BP: _____

Pain: ___ (0-10)

Nl	Abn	
❒	❒	General Appearance:
❒	❒	Head:
❒	❒	Eyes:
❒	❒	ENT:
❒	❒	Neck:
❒	❒	Chest:
❒	❒	Heart:
❒	❒	Abdomen:
❒	❒	Genitals:
❒	❒	Musculoskeletal:
❒	❒	Skin:
❒	❒	Neuro:

Vision Screening
Right:
Left:

Assessment

Plan
Anticipatory Guidance
Immunizations: Influenza
Other:

Follow-up:

Addressograph

_____
Examiner's Signature/Name Stamp

School Age (6yr-9yr) Well Child Visit
Parent Questionnaire

1. How often does your child brush his/her teeth?_____
2. How often does your child see the dentist?_____
3. Do you provide your child healthy food choices and nutritious snacks? Yes/No
4. Does your child have any sleep problems? Yes/No
5. Do you encourage your child to read? Yes/No
6. Do you try to regulate your child's television-watching (time, content)? Yes/No
7. Does your child have any responsibilities at home (chores)? Yes/No
8. Are there any smokers in the household? Yes/No
9. Does your child play with matches, candles, lighters, or fireworks? Yes/No
10. Is there is a gun in the home? Yes/No
11. Does your home have working smoke detectors? Yes/No
12. Does your child know how to swim? Yes/No
13. Does your child wear a life jacket when in a boat? Yes/No
14. Has your child learned to cross the street safely? Yes/No
15. Does your child wear a bicycle helmet when riding a bicycle, scooter, or skateboard? Yes/No
16. Do you ever seat your child in front of a passenger air bag? Yes/No
17. Do you help your child with his/her homework? Yes/No
18. Have you talked to your child about puberty/sexuality? Yes/No
19. How is your child restrained when he/she rides in a car?
20. How do you discipline your child?
21. Do you fear for the safety of yourself or members of your family? Yes/No
22. What questions do you have for your child's provider today?